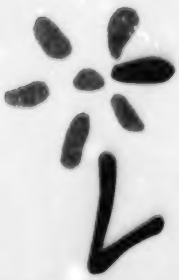
A Handbook Dealing with Woman Abuse and the Canadian Criminal Justice System: Guidelines for Physicians



Canada

A Handbook Dealing with Woman Abuse and the Canadian Criminal Justice System: Guidelines for Physicians

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Health Canada

A Handbook Dealing with Woman Abuse and the Canadian Criminal Justice System: Guidelines for Physicians was prepared by **Lorraine E. Ferris**, **Asifa Nurani** and **Laura Silver** for the Family Violence Prevention Unit, Health Canada.

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FOREWORD

Abuse is common, and in one way or another, no matter what our circumstances, we have all been victims of those who seem compelled to use psychological, sexual or physical abuse to assert their power over us. Yet both victims and witnesses are too often reluctant to report or redress the wrong, perhaps from the misguided belief that nothing can be done about it, that it was an isolated incident, that any reaction may incite more abuse or other consequences, or that the victim in some way may have done something to deserve it.

Abuse of women by their partners or spouses is particularly disturbing because it is common and is complicated by the interdependency of the relationship between a man and a woman. Furthermore, others who might be able to do something—such as physicians—are often reluctant to invade the privacy of the relationship even when they suspect abuse might be occurring, and they shy away from involvement in situations that may have legal implications.

With the leadership and financial support of Health Canada, psychologist and epidemiologist Lorraine Ferris, public health specialist Asifa Nurani and lawyer Laura Silver have produced this collaborative work not only to demonstrate the magnitude of the problem but also to guide physicians in recognizing the manifestations of woman abuse, documenting them sufficiently so that the evidence will be credible in court, and helping the victim gain access to the relevant community resources. Wherever possible, the authors have documented the evidence supporting their recommendations and have been straightforward in indicating when evidence is equivocal or absent.

Physicians have a critical responsibility to recognize and respond to the abuse of women. This handbook is an important step in helping them meet that responsibility.

Bruce P. Squires, MD, PhD
May, 1998

Bruce Squires is the former editor-in-chief of the Publications Department of the Canadian Medical Association and the Canadian Medical Association Journal. *He is currently vice-president of the World Association of Medical Editors.*

PREFACE

Ms. D. presents for her well-woman examination. During the functional inquiry, she reports insomnia and symptoms compatible with anxiety. She has multiple bruises and a resolving black eye, and when asked how these injuries were caused, she gives a very improbable story. Suspecting that she is being physically abused by her partner, the physician mentions that sometimes people have injuries such as these because someone has hurt them, and then asks her directly and empathetically if this is occurring. She acknowledges that it is.

Given the prevalence of this problem, there is a high likelihood that every physician has seen or treated cases of women who have been assaulted by their partners. In a Statistics Canada national survey[1] of 12,300 women over the age of 18, 30% (who had ever been married or in a common-law relationship) reported having been assaulted by their male partner at least once; almost 20% more than once, and almost 10% more than 10 times. Between 1974 and 1990 in Canada, the rate of murder of women by their spouses was 0.83 per 100,000.[2]

In this handbook, which is intended for practising physicians and medical students, we examine the issue of woman abuse, particularly as it pertains to physicians' interactions with the Canadian criminal justice system, and we make recommendations about professional practice. Chapter 1 provides background information about woman abuse and introduces the medico-legal interface. The remaining chapters review practice issues, background information and clinical recommendations. In each section we refer to other guidelines; no one set of guidelines is known to deal with all the areas discussed here.

In this handbook, we define "woman abuse" as "physical or psychological abuse directed by a man against his female partner in an attempt to control her behaviour or intimidate her."[3] We consider here all forms of abuse for the purpose of exercising power and control—physical, psychological and emotional, economic and sexual; however, psychological, emotional or economic abuse (unless it is fraud) are not punishable as criminal offences. (We do not deal with abuses perpetrated by women on men or by women in lesbian relationships.)

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CHAPTER 1

INTRODUCTION

Woman abuse as a major public health issue

In Ontario between 1974 and 1990 an average of 32 women were killed by their partners each year—61% to 78% of all women killed in the province.[2] The rate of spousal homicide throughout Canada is similar.[3] The probability of a Canadian woman being killed by her spouse is nine times greater than the probability of her being killed by a stranger.[4] As well, more women are injured or killed by woman abuse than by automobile crashes, muggings and rapes combined.[5] Over the past decade, three times more women than men have been killed by their spouses each year. In 1996, 78% (62) of all spousal homicide victims were women and 22% (18) were men.[6]

According to Statistics Canada, in 1996, 49% of all solved firearm homicides involved acquaintances, 18% involved a spouse, 22% involved other relatives, and 11% involved strangers; in all, 34% (27) of all spousal homicide victims were killed by firearms.[7] Leesti[8] reported that between 1985 and 1994 the leading method used to kill a female spouse was shooting (40%), followed by stabbing (25%), beating (18%) and other means (17%).

Battered women suffer both physically and psychologically and are therefore high consumers of medical care. According to a Statistics Canada national survey of 12,300 women over the age of 18, 40% of the abused women reported requiring medical attention for physical injuries related to the abuse.[1] They also reported that 45% of the assaults resulted in injuries, including bruises (90%); cuts, scratches, or burns (33%); and broken bones (12%). Day[9] estimated that in 1992, 28% of battered Canadian women sought medical care because of abuse at an estimated cost to the health care system of $1.5 billion. She asserted that these costs represent only the tip of the iceberg and that many cases go undetected. Some U.S. authors concur with Day's conclusion.[10-12]

Determining the proportion of abused women who seek medical assistance for woman abuse is difficult, but it is estimated to be between 8% and 39%.[13,14] Compared with 1,718 women who had formerly been abused, 108 who were currently being abused were more likely to be receiving medical assistance and visiting hospital emergency rooms, to have more physical symptoms, to exhibit higher levels of depression, anxiety and somatization, to have lower self-esteem, and to have attempted suicide; they and their partners were also more likely to be dependent on drugs or alcohol.[15] McLeer and Anwar[16] reported that 30% of injured women presenting to emergency departments were injured during domestic violence. Hamberger, Saunders and Hovey[17] found that of the 394 women seeking health care in a family practice setting, 22.7% reported having been physically assaulted by their partners in the last year.

According to the Statistics Canada survey,[1] the most prevalent reported forms of physical abuse of women who have ever been assaulted are pushing, grabbing and shoving, with one of these aggressive acts being carried out in 25% of cases. Many of the women (44%) reported having had a weapon used against them and 36% of these said the weapon was a gun or a knife. About one third of respondents who reported experiencing abuse, including 13% of women who were currently in abusive relationships, said that they had feared for their lives at some point in the relationship.

Episodes of assaultive behaviour typically increase in frequency and worsen in severity, despite the abusers' reassurances that the behaviour will never be repeated.[18] From what we know, the assaultive behaviour will not end on its own without intervention.[3]

In spite of the prevalence of woman abuse and the high rate of visits by abused women to physicians, detection rates by medical practitioners are low.[11,12,14,19,20] Even when patients exhibit classic physical injuries and associated emotional and psychosomatic problems, physicians fail to make the appropriate diagnosis.[14,21,22] In their study with a national volunteer sample of 854 American women, Bowker and Maurer[14] found that despite having been seriously assaulted over extended periods, only 334 (39%) of those who used medical services reported having, on at least one occasion, received help related to the treatment of their injuries from physicians or nurses. Stark, Flitcraft and Frazier[12] found that 25% of abused women had sought health care at least 11 times for trauma and that another 23% had made six to ten independent visits to physicians because of abuse injuries.

The reasons for physicians not detecting woman abuse are complex and likely stem from a combination of factors including confusing clinical presentation,[23] lack of direct inquiries about the possibility of abuse,[11] lack of training,[14,24] inappropriate attitudes and practices,[25,26] the reluctance of patients to openly acknowledge the abuse,[27,28] and having both partners in the practice.[29]

The medical/legal interface

Woman abuse is a criminal offence. Therefore, along with detecting cases of woman abuse and treating the medical problems, physicians must also deal with the criminal justice system when a perpetrator is charged. Although it is not specifically listed in the Canadian *Criminal Code*, most forms of woman abuse are considered to be criminal: physical assault, sexual assault, criminal harassment, intimidation and threatening. Psychological abuse alone is not criminal (Table 1).

Table 1. Examples of abuse that are and are not considered crimes in Canada

Examples of physical abuse that are crimes in Canada	hitting, pinching, slapping, pushing, punching, kicking, burning, choking, biting, shooting, stabbing, cutting
Examples of sexual abuse that are crimes in Canada	sexual touching or sexual activity that is unwanted and not consented to
Examples of emotional or psychological abuse that are crimes in Canada	making threats to harm a person or a third party; damaging property; repeatedly following or communicating; watching or behaving in a threatening manner (stalking or criminal harassment)
Examples of emotional, psychological and economic abuse that are not crimes in Canada	humiliating; insulting; ignoring; screaming; calling someone names; telling someone what they are or are not allowed to do, where they can go, and who their friends can be; refusing to let someone have any money; refusing to allow someone to get a job

Adapted from: *Abuse is wrong in any language.* Ottawa, Ontario: Department of Justice Canada and the Attorney General of Canada, 1995. Report No. HV 6626.23C3A38.

Because woman abuse is a crime, physicians need to understand how the criminal justice system operates and the role they may play in it. For example, medical documentation may play an important part in proving or disproving criminal conduct. It may also promote a more expeditious or satisfactory resolution of the criminal case. Medical documentation will describe in detail the nature and extent of the victim's injuries and may be relied upon to corroborate her allegation of abuse. The corroborative evidence may strengthen the prosecution's case against the accused, or persuade the perpetrator to plead guilty, sparing the victim the ordeal of testifying and saving the community unnecessary legal costs. Likewise, absence of confirmatory evidence in the medical documentation may assist in identifying an unwarranted criminal charge. In cases where the victim has delayed making a formal complaint to police, medical documentation may confirm the contention that abuse has been continuing or is escalating.

The criminal justice system has responded to the problem of woman abuse by developing coordinated strategies that include legislative reforms and police involvement, Crown attorneys, and probation and parole officers. Police have been mandated to charge offenders whenever reasonable and probable grounds exist to believe that an offence has been committed—irrespective of the wishes of the victim. Crown attorneys have been given the authority to prosecute perpetrators of woman abuse cases vigorously, and probation offices are setting up special counselling programs to help offenders understand their problem and to break the cycle of violence. The level of services available for victims may vary from one jurisdiction to another.

Conclusion

Cases of woman abuse are a major challenge for physicians, involving not only the need to identify that abuse is occurring and to deal effectively with it, but also to deal with the criminal justice system. As the legal system and courts develop a more coordinated and rigorous response to the problem, physicians are bound to be more involved with the legal system. In a national study of Canadian primary care physicians, 74.4% of the survey sample identified a need for more education about these legal issues and indicated their willingness to attend sessions that would provide such education.[28] This handbook responds to that identified need.

CHAPTER 2

PHYSICAL MANIFESTATIONS OF WOMAN ABUSE

Clinical practice points

- Early identification of suspected woman abuse is important for a high quality of care.
- Early identification of woman abuse aids legal efforts to address the violence.

Background

Woman abuse is so widespread that all physicians need to develop the skills to assess, identify and treat its victims. Several authors show that physicians often do not suspect abuse even when they are treating "classic" physical injuries and associated emotional and psychosomatic problems.[14,21,22] This chapter describes the likely presentation of physical woman assault.

Physical injuries resulting from woman abuse typically include trauma to the head, face, neck, breasts and abdomen, and tend to be concentrated in areas that are readily hidden by clothing.[30] They are distinguishable from accidental injuries, which typically involve the periphery of the body. Stark and colleagues[12] reported that victims of domestic violence are 13 times more likely than accident victims to sustain injuries to the breast, chest or abdomen. In pregnant women, assaults to these areas of the body are common and may escalate during the pregnancy.[31,32] There may be abrasions or outlines of an object, such as a belt buckle, or burns from appliances, stoves, cigarettes, acid or scalding liquid.

Because an abused woman may have endured several beatings over time, she may present with several minor injuries at various stages of healing:[33] for example, old yellowing bruises alongside new ones. Because violent men tend to repeat the same behaviours from one episode to the next, a victim may have a cluster of injuries at various stages of healing—all to the same area of her body. Abuse should be suspected in the case of any woman who presents with obvious multi-stage injuries.[34,35] Battered women often delay getting treatment, and sometimes the untreated injuries will be revealed only through radiological examination.[31]

Firearms are often used in woman assault (Chapter 1). Most physicians will not likely be treating women with gunshot wounds, but they should recognize that gunshot wounds are strong indicators of woman abuse by a partner rather than assault by a stranger.

Finally, the stress of living in a continuing abusive environment may result in recurring ailments, including headache, insomnia, choking sensations, hyperventilation, and gastrointestinal, chest, pelvic and back pain.[19,36] Abuse should be suspected in any woman who presents once or, especially, repeatedly with continuing vague complaints and who is evasive, avoids eye contact, appears ashamed or embarrassed, or has injuries that do not match her explanation of how she sustained them.[12,37]

Screening for woman abuse takes two forms: interview and physical examination. In the interview, physicians should ask about her previous experiences with violence and the presence of risk factors for violence such as firearms in the home. It has been suggested that victims are more comfortable sharing this information with physicians than with other professionals,[20] but the degree of sensitivity and specificity of such questions asked by the physician are not known.[38] In the physical examination, the appearance or location of burns, bruises and other lesions may suggest abuse. Multiple injuries without a plausible explanation are also suspicious. The sensitivity and specificity of this form of screening used by physicians are not known.[38]

Abuse during pregnancy

The prevalence of women experiencing violence during pregnancy has been estimated to be between 0.9% and 20.1%, while the prevalence of violence at any time

ranges from 9.7% to 29.7%.[39] Research has not yet confirmed whether pregnant women are at greater risk for violence initiated during pregnancy or, for women experiencing continuing violence, whether the severity or frequency of violent incidents increases or decreases, or whether violence ceases altogether.[40] In a study of 742 women seen in obstetric clinics, Hillard[36] reported that 81 (10.9%) women had experienced abuse in the past and that 36% of these said the abuse had decreased during pregnancy. Another study by Hilberman and Munson[19] reported that pregnancy was associated with a decrease in domestic violence, with the result that some women may try to protect themselves by repeatedly getting pregnant. However, in a large community survey, the rates of violence were found to be higher in households where the wife or female partner was pregnant at the time of the interview.[41] A pregnant woman's risk of minor violence was found to be 28.3% greater than that of a non-pregnant woman, her risk of more serious violence to be 60% greater, and her overall risk of any form of violence to be 35.6% greater. Another survey conducted by Statistics Canada[42] reported that 21% of women abused by a current or previous partner were assaulted during pregnancy.

Trauma during pregnancy may have significant negative implications for both the mother and the unborn child, including miscarriages, abruption of the placenta, fetal loss, premature labour, premature delivery and low birth weight.[22,43,44] Other problems that may affect pregnancy, such as substance abuse, poor nutrition, depression and late or sporadic access to prenatal care may also be associated with abuse.[33] Lent[45] and Gelles[46] have suggested that the increased risk for abuse during pregnancy may be related to the abuser's ambivalence about the pregnancy, the increased vulnerability of the woman, mounting economic pressures and decreased sexual availability. In a random sample of 290 pregnant women, Helton, McFarlane and Anderson[47] found that the primary predictor for woman abuse during pregnancy was prior abuse. In this study, 87.5% of those women who were battered during pregnancy had also been abused before the pregnancy. Stewart[48] reported that 95% of 30 women who were abused during their first trimester of pregnancy were also abused in the postpartum period, and that the mean number of incidents of abuse per woman (2.1) was significantly higher during the postpartum period than during the three months before conception (1.5).

Further research is needed to understand the occurrence and timing of violence during pregnancy so that data-based prevention and intervention programs may be developed.[40] However, tremendous progress has been made in establishing that abuse during pregnancy does occur more often than other routinely screened complications of pregnancy (e.g., gestational diabetes, pre-eclampsia) often with severe health consequences.[39,49]

Sexual assault

An often neglected but integral part of violence between intimate partners is sexual assault. In one of the first studies that identified the prevalence of marital rape, Russell[50] estimated that 14% of ever-married women have been sexually assaulted by their husbands at least once. In 1980, Frieze[51] reported that 34% of a sample of battered women said they had been raped by their spouse. The American Medical Association[52] reported that women of all ages are more vulnerable to sexual assaults perpetuated by partners or ex-partners than to rape by acquaintances, other family members and strangers combined. The American Medical Association[53] also stated that sexual abuse occurs most frequently in relationships in which other forms of abuse are also present and, although the source of the evidence is unclear, that rape is a significant or major form of abuse in 54% of violent marriages.

Few victims of violence identify their experiences as assault. Koss, Gidycz and Wisniewski[54] found that only 27% of women whose experiences met legal definitions of rape labelled themselves as rape victims. Women who were assaulted by strangers were more likely to view their experiences as rape. Most women did not consider their experiences as any kind of crime, although they readily admitted that these experiences were extremely distressing.[54,55]

Chapter 4 provides information for the physician on the physical examination in cases of confirmed or suspected sexual assault.

Recommendations

- Strongly consider woman abuse when the injuries sustained do not fit the history given.
- Look for evidence of previous injuries or injuries that are at different stages of healing.
- Be aware of the common sites for injuries (e.g., head, neck, face, throat, chest, abdomen) and clusters of multiple injuries.
- When performing a physical examination, visually examine under the patient's gown for injuries to the ribs, breasts, groin and other body parts covered by clothing.

- Watch for injuries to bone or soft tissues, including lacerations to head or face; broken teeth; fractured or dislocated jaw; contusions; abrasions; pulled-out hair; black eyes; perforated eardrums; burns and scalds caused by cigarettes, hot grease, stove elements and acids; fractures of clavicle or ribs; strangulation marks; internal injuries; bite marks; retinal hemorrhage; and evidence of sexual assault.

- Consider the possibility of violence when there have been multiple visits to an emergency department.

- Gunshot and stabbing wounds are strongly linked to woman abuse and should be treated as highly suspicious unless there is strong evidence to suggest the attack was not by a partner.

- Watch for signs of sexual assault.

Other guidelines

These recommendations are consistent with those of other groups.[18,52,56] Although the question of whether pregnancy poses a particular risk for abuse is not yet definitively answered by research studies, most guidelines suggest that abuse increases or begins during pregnancy.[18,56] Regardless, abuse during pregnancy can have a significant negative effect on a woman and her fetus and that abuse will occur more often than other pregnancy complications (e.g., gestational diabetes).

CHAPTER 3

PSYCHOLOGICAL MANIFESTATIONS OF WOMAN ABUSE

Clinical practice points

- Psychological abuse may accompany or lead to physical abuse, and needs to be addressed to ensure appropriate quality of care.
- Psychological reactions to abuse are sometimes puzzling.

Background

Types of psychological abuse

Women who are abused physically are usually abused psychologically as well. Like physical abuse, psychological abuse is employed to establish dominance and control over another person.[57] It may involve any of the following: social isolation of the victim; excessive jealousy and surveillance; threats of harm; intimidating acts; oral denigration; attribution of blame for the abuse to the victim; name calling; public embarrassment; shouting; berating; harassment; destruction of the victim's self-esteem; and cycles of acute battering alternating with repentance and reconciliation.[58-60]

Psychological abuse is not a criminal offence (except as noted in Chapter 1, Table 1), but it should still be taken seriously by physicians because it may be an early marker for physical abuse[61] and may have a damaging effect on the woman and her well-being.[32,41] Several major categories of psychological maltreatment may have a cumulative impact. For example, economic abuse—such as forbidding the woman to work, getting her fired, limiting her access to money, refusing to pay her bills, ruining her credit history, and not paying child support—may be demeaning, lead to social isolation and heighten the woman's anxiety about providing basic necessities for herself and her children.[62]

A woman's psychological reactions

The term "battered woman syndrome" is used to describe a variety of behaviours and coping strategies exhibited by abused women. The most common symptoms associated with this syndrome include fear, depression, guilt, low self-esteem, and symptoms associated with post-traumatic stress disorder. These symptoms are believed to be coping strategies that help the victim deal with the abuse; however, they may also contribute to a paralysis that fosters staying in the abusive relationship rather than leaving.[63]

Jaffe et al.[64] found higher rates of clinical depression and somatic complaints in women who had been abused than in those who had not. Others have found higher rates of depression, anxiety disorders and substance abuse,[65,66] mental illness, alcohol and drug abuse, suicide,[67] headache, insomnia, choking sensations, hyperventilation, gastrointestinal pain, chest pain, pelvic and back pain, depression, lowered self-esteem, signs of anxiety neurosis, suicidal ideation, substance abuse, and non-compliance with medication.[15,23,53,68]

If the abuse includes sexual violence there are additional concerns. Kilpatrick et al.[69] interviewed a representative sample of 2,004 adult women about their experiences of victimization and their mental health problems; 19.2% of sexual assault victims but only 2.2% of non-victims (women who did not fit into one of the eight victimization categories) had attempted suicide. In a study of 2,099 women, Groeneveld and Shain[70] found that use of sleeping pills was 40.5% higher and use of drugs to relieve anxiety was 74% higher in the 7.7% who had been abused than in those who had not. In a community-based sample of 406 married women, Ratner[71] found that those who reported being physically abused were 8.1 times more likely to be alcohol dependent than those who had not been abused, and those who reported being psychologically abused were 5.3 times more likely.

Finn[72] found that one in seven battered women abused alcohol and one in ten abused or overused drugs, especially prescription medications such as sedatives and sleeping pills, apparently to palliate the fear and anxiety accompanying the battering.[12,72] Physicians should ask women about abuse before prescribing drugs or other treatment that may be serving only to make an abusive situation more tolerable.[12,72]

Recommendations

- Consider the possibility of psychological abuse (with or without accompanying physical violence) when there is:
  - fear of, or anger toward, the male partner;
  - stress, post-traumatic stress disorder, other anxiety disorders or depression (e.g., sleep and appetite disturbances; fatigue; chronic headaches; reports of severe crying spells or feelings of isolation; suicidal thoughts; acute anxiety attacks; chronic pain without identifiable cause; headaches; pain in the back, chest, or stomach; gastrointestinal and abdominal complaints; palpitations; dizziness; paresthesias; dyspnea);
  - frequent occurrence of gynecologic problems, pelvic pain; and
  - frequent or long-term use of prescribed minor tranquilizers, pain medications or psychoactive drugs.
- Help the patient to recognize the range of abusive behaviours she is enduring and let her know that she does not deserve this treatment.
- Consider the possibility of abuse when there is a history of suicide attempts, long-term use of psychoactive drugs, history of psychiatric illness or substance abuse.
- Be highly suspicious of physical abuse and watch for it routinely.

Other guidelines

These recommendations are consistent with those from other groups.[18,52,56]

CHAPTER 4

THE ROLE OF MEDICAL DOCUMENTATION IN PROVIDING HIGH-QUALITY CARE AND IN LEGAL PROCEEDINGS

Clinical practice points

- The medical documentation should ensure high-quality and continuous care for an abused woman.
- The medical documentation in cases of woman abuse must include all appropriate information and all clinical evidence.
- Medical documentation may be used by police, lawyers, and the courts to prove that a crime has been committed; it therefore has a role in legal proceedings.

Background

Unlike most other health concerns, woman abuse requires communication between medical and legal specialists. Physicians who treat battered women are not required to gather legal evidence, but they are likely to be direct or indirect participants in any ensuing legal proceedings. If the perpetrator of the abuse is charged, lawyers and courts may rely on the medical record documenting injuries to the victim to provide concrete evidence of the alleged violence. Therefore, physicians need to know what information they should include in the victim's medical record.

Contents of the medical record

The clinical presentation of woman abuse may be confusing; therefore, appropriate documentation is essential to its identification and appropriate follow-up. To make an accurate diagnosis and initiate suitable treatment, physicians need to inquire appropriately about the nature and cause of the presenting injuries. If a patient's physical injuries are not consistent with her explanation of how they occurred or if she has continuing complaints that do not have an organic origin, physicians must consider the possibility of abuse.

Practitioners must maintain careful clinical records. Generally, it is best to query in the medical record whether injuries are the result of woman abuse as soon as it is suspected, much as one would document other working hypotheses of the cause of an illness.

For both medical and legal purposes, the medical documentation—described by Sharpe[73] as "the grindstone on which the doctor may sharpen his or her memory about what transpired during the visit or consultation"—must be comprehensive and precise. The record should include the patient's relevant medical history; a detailed description of the injuries and their origin; a body map; results of all laboratory and diagnostic testing; the medical treatment required; whether hospitalization was required; progress during hospitalization; and condition at time of discharge. A detailed history, in the patient's own words, of the reported cause of the injury should be documented (omitting any long statements that deviate from the abuse). The record should also outline any written or oral information provided by the physician to the patient.

All injuries should be described as specifically as possible, including information on type of injury, location (in relationship to fixed landmarks or standard anatomical regions), length and width (cm.), shape, and colour and depth if appropriate.[74] An anatomical diagram should be used to indicate the details of the physical examination. The record should indicate those body parts that have been injured, those that are functioning normally, and those that have been affected by injury or disease before the incident in question.

If clinical specimens are taken, it is important that the medical record clearly state what was collected and to whom it was transferred. Chapter 5 discusses this in more detail.

The record should include information about the woman's psychological state and should refer to all sources used to draw conclusions. The physician should also note the

woman's psychological demeanor, including facial expressions and gestures. If it was not possible to examine or interview the woman without the male partner present, this should be mentioned.

If possible, photographs should be included in the medical chart; they clearly document the exact locations and appearances of injuries and are considered to be compelling evidence in criminal court. Obviously, in the course of everyday medical practice, taking photographs may not be realistic, and the physician will not be held accountable for not having documented injuries in this way. However, physicians should consider offering to do so if at all possible, and those with many female patients in the practice should consider purchasing a camera. It is necessary to obtain the patient's written consent and to observe the following guidelines:[75]

- Take photographs with a colour Polaroid™ camera. Colour may be an important characteristic of the injury, and use of a Polaroid™ camera allows for immediate confirmation of whether the injury has been captured appropriately on film.
- If possible, photograph all visible injuries before any medical intervention. If treatment is necessary, photographs should be taken after the intervention as well.
- Clean any wounds before photographing them, unless it is important to capture their initial appearance. (From a legal perspective, it would be best to take photographs before wounds are cleaned and then, perhaps, afterwards.)
- Photograph injuries from several angles and use a reference object (e.g., a coin or ruler) to show the size of the injury.
- Include the patient's face or hand in at least one picture to ensure she is identifiable.
- Take at least two pictures of each injury: one at a distance to include anatomical landmarks that locate the injury site and one at a closer range to capture details.
- Include the following information on the back of every photograph: name of patient, date, location of the injury, name of photographer, names of witnesses in attendance, and name of the attending physician.

Retaining and transferring medical records

According to Sharpe,[73] any medical record should be retained until the physician is satisfied that it will not be required for the continuing care of the patient, to justify income tax payments, or to defend a legal action. At a minimum, records should be kept as long as required by provincial or territorial licensing authorities or government health-insurance plans. In cases of assault, the period for which records should be retained may depend on the limitation period for such criminal proceedings in the jurisdiction in which the practice is located. In Canada, there is generally no fixed limitation period in which a criminal charge can be laid. From a practical perspective, police and prosecutors may be unwilling to initiate proceedings if a case is old because problems of proof may arise; however, exceptions may be made in woman abuse cases because victims tend not to report the assaults immediately. It may take years for a victim to report, if she ever does. Therefore, the length of time records should be kept in these cases is difficult to specify. As there may be no way of knowing how long the abuse has been going on and whether charges will materialize, physicians should consider keeping medical records in abuse cases longer than they would ordinarily keep records in other cases.

A related issue is how to handle a request by a patient to have her medical record transferred to another physician. Physicians are advised not to transfer records in this case, because doing so may mean that the original author will not have his or her original notes should there be an inquiry or legal action.[73] Sharpe[73] has suggested that, with the patient's written permission, a summary of the pertinent information in the medical record should be sent to the other physician.

Recommendations

- Include in the medical documentation of woman abuse:
  - the medical history;
  - the patient's chief complaint (verbatim);
  - a description of the abusive event (verbatim);
  - a detailed description of injuries, including type of injury, location (in relationship to fixed landmarks and standard anatomical regions), length, width, shape, colour and depth;

- laboratory and other diagnostic test findings;
- diagnosis;
- a record of the medical treatment provided; and
- photographs, if taken.

- Carefully document what clinical specimens were collected and to whom they were transferred (Chapter 5).
- In suspected cases of abuse, consider keeping medical records for longer than usual because there is no way of knowing when or whether they may be required in a criminal case.
- Do not transfer a medical record to another physician: consider instead, with the patient's written permission, sending a summary of the pertinent information contained in the record to the other physician.

Other guidelines

These guidelines are consistent with US[52] and other Canadian[29] guidelines.

CHAPTER 5

PRESERVING EVIDENCE

Clinical practice points

- Physical evidence pertaining to an assault must be collected and saved.
- A protocol to ensure the validity of the evidence must be followed if the evidence is to be used in court.

Background

The abuse inflicted on a patient may be considered criminal; therefore, any evidence collected during a medical examination must be properly preserved. Evidence may include photographs taken by the physician, medical charts, samples of body fluids, weapons, torn clothing, broken objects, etc. For an item to be admissible in a court of law, there must be continuity of evidence that establishes that the item is truly what it purports to be and that the sample has been handled in such a way that it has been kept free from contamination. If a clinical specimen is taken, the physician must document that the specimen came from the patient and that the test was administered correctly.

If physical evidence pertaining to an assault is obtained during the medical examination, it must be collected carefully so that it will be admissible in court. The item must be clearly identified, but the identification marks must not affect the evidence. Do not mark the items directly; rather, place each clinical sample or specimen in a container (e.g., blood vial, specimen jar, envelope) labelled with the patient's name, hospital identification number, date of collection, nature of the specimen and initials of the collector. To prevent decomposition, items stained with body fluids should be air dried prior to packaging. Blood samples should be refrigerated.

The patient's medical record should indicate what samples were collected and designate to whom they were transferred (e.g., laboratory, police officer). Each successive transfer of the evidence should be documented, as any break in the continuity may result in inadmissibility in court.[74] If evidence is to be collected and then saved (e.g., in cases where a victim has not yet decided to press charges), efforts should be made to ensure that it is maintained in good condition. Envelopes, specimen containers, and so on should be sealed, taped, and initialed so that they are tamper-proof, and then stored in a safe place.

Recommendations

- Know what evidence may be needed for court proceedings.
- Know the legal protocol for collecting and preserving evidence for court.
- If you are in doubt, contact your medical association, college, legal defence association or private solicitor.
- If police are involved, have the appropriate telephone number available in case you need to ask questions or obtain advice about collecting and preserving evidence.

Other guidelines

These guidelines are consistent with others.[29,76]

CHAPTER 6

ASKING A PATIENT ABOUT THE POSSIBILITY OF WOMAN ABUSE

Clinical practice points

- Victims of woman abuse will often visit a physician if they need medical attention.
- Victims may be more likely to reveal the existence of the abuse if they are asked about it.
- Detecting abuse increases the likelihood that medical, social service, and legal interventions can be started before the woman suffers more serious injuries or is killed.

Background

An abused woman will more likely seek assistance from her family physician than from psychiatrists, police officers or lawyers.[20,32,77] One study found that at least once while they are in abusive relationships, one third of battered women see their family physician.[78] Despite this, the rates of detection by physicians are low.[12,14] Failing to diagnose a case of domestic violence could result in inappropriate treatment, including prescription of sedatives or anti-depressants, which may lead to increased risk of suicide or even place the woman at greater risk of escalating violence.[52]

Inquiring about the possibility of abuse

One reason for the low detection rate may be that physicians do not ask about the possibility of abuse during routine functional inquiries. Friedman and others[79] surveyed patients and physicians at two primary care clinics in Boston. Of the 164 patients, 16% reported experiencing physical abuse; of these, 81% favoured routine inquiry. Of the 27 physicians, 67% reported never asking about physical abuse at the first visit, 59% reported not asking at annual visits, and none reported asking routinely. In Chapter 7, we discuss in detail the issue of routine screening versus screening only in suspicious cases.

In a 1995 survey of 648 women presenting at several health care sites in Denver, the incidence of acute domestic violence among women presenting to the emergency room was 11.7%.[80] Although 47 women presented with acute signs of abuse, only six were questioned about domestic violence. A subsequent chart review of all available records revealed that acute domestic violence had been documented in only two of 828 charts.

A Canadian study[11] of 29 family physicians showed that 38% never ask patients directly about the possibility of violence. However, a large national study of 963 family physicians and general practitioners found that almost all believe that they should be asking this of women with suspicious injuries (98.8%) and emotional difficulties (97.7%).[28]

If a woman is not asked about abuse, she will usually not bring it to her physician's attention,[80] possibly because she fears reprisal, is ashamed of her situation, or fears a breach of doctor–patient confidentiality. Some reports suggest that these feelings can be heightened if the woman's partner is known to the physician.[18,81]

Rounsaville and Weissman[82] found that if battered women had been directly asked about abuse, most would have disclosed the facts. Others have also found that if a family physician had asked in a supportive way about domestic violence, the women would have acknowledged its existence.[20,83] This highlights the importance of physicians asking about abuse if appropriate medical care is to be ensured.

How to ask about the possibility of abuse

Basically, there are two ways to ask about abuse. The first is to use a specific screening instrument that is either administered as an interview or is self-administered. The second is to incorporate some questions about abuse into

the patient interview. The US Preventive Services Task Force[84] states that there is insufficient evidence to recommend "for or against the use of specific screening instruments for family violence"; however, the Task Force also states that asking a few direct questions about abuse may be recommended. Here, we describe how physicians could ask female patients about abuse.

First, creation of a facilitating and non-judgmental atmosphere for interviewing the patient is essential.[5,52] If possible, the woman should be interviewed alone, and if others are present it should be noted in the medical record.[29] A particularly difficult situation may arise with women who are not fluent in their physician's language because they may wish to have a family member or friend with them as interpreter during the interview and examination; asking about abuse is then very difficult. It may be possible to find a hospital or clinic staff volunteer who speaks the patient's language and who could attend, but practical issues may intervene. Alternatively, the woman may be referred to an appropriate clinic or health centre with personnel who can communicate in her language and understand her culture.

Even if the woman is interviewed or examined alone, she may still be reluctant to identify abuse as the cause of her injuries because of fears for her safety, embarrassment, a desire to protect the abuser, or reliance on the family finances.[29,52] Although domestic violence occurs in every social class, at every income level and among all ethnic groups,[85] a woman's cultural and religious beliefs may influence her perceptions of abuse.[52] Questions should be posed in clear and simple language and be neither judgmental nor intimidating. It is also suggested that the patient be asked about specific acts rather than a global problem; for example, it may be better to ask about slapping or hitting rather than about "domestic violence."

It is unclear whether a direct or an indirect questioning approach is best. Some suggest beginning with direct questions and switching to indirect if needed, while others believe it is best to start with indirect questions.[86] Indirect questions could include:

- "How are things going in your relationship?"
- "How do you and your partner deal with conflict?"
- "What happens when you or your partner gets angry?"
- "You mentioned that your partner uses alcohol. How does he act when he has been drinking too much?"

Direct questions could include:

- "Are you afraid of your partner?"
- "Has your partner ever forced you to have sex when you didn't want to?"
- "Sometimes people get injuries like these because someone has hit them. Did someone hit you?"

Physicians may decide to use either a direct or an indirect approach based on considerations such as how well they know the patient, how receptive the patient is, and the strength of the evidence (e.g., highly suspicious physical injuries versus possible psychological manifestations of abuse). Open-ended indirect questions are better from a legal perspective because they preclude a criticism that the witness's evidence has been contaminated by inappropriate suggestion or leading questions. However important these concerns, there are no research studies that directly compare the two interviewing styles; the physician's clinical judgement may be the best guide.

Asking about sexual assault is difficult because many women in intimate relationships may not label violent sexual acts as assault.[50,87] It may be best to phrase the question as "Did anyone force you to do something you didn't want to do?" rather than asking "Were you sexually assaulted?" Again, this is a matter of direct versus indirect questioning, and direct questions may be considered leading should the case go to court. Clinical judgement about how best to provide high-quality medical care to a patient, and concerns such as sexually transmitted diseases or unwanted pregnancy need to be considered in this decision.

Abused women who have children should always be directly asked whether their partner ever hits or abuses the children. If the woman identifies a history of child abuse, or if child abuse is suspected, child and family services must be contacted. Physicians need to know their legislative reporting duties with respect to suspected child abuse, including how, to whom and on what grounds to make a report. Also, the woman should be informed of the legal requirement to report child abuse. The American Medical Association[52] suggests that when child abuse is suspected there should be a coordinated effort between "advocates for victims of domestic violence and child protective service agencies" to ensure that the safety needs of both women and children are met.

Physicians need to know that there is evidence that men who abuse their partners are also likely to abuse their children[20] and that 30% to 40% of children who witness domestic assaults also experience direct physical abuse themselves.[88]

Recommendations

- Be alert to suspect woman abuse.
- Ask simple questions.
- Use clinical judgement to decide whether direct or indirect questions should be asked.
- If there are children in the home, ask questions about whether they are being abused.
- Be empathetic.
- Be non-judgmental.
- Interview the woman alone if possible and in a confidential setting.
- Make an opening supportive statement (e.g., "I am concerned about your injuries").
- Advise the patient that information will be kept confidential unless there is a legal requirement to disclose it.

Other guidelines

For the most part, these guidelines are consistent with others.[18,52,56] However, it is clear that clinical guidelines strongly favour using direct questions[52,56,89–91] rather than leaving it to the physician's clinical judgement, as we have recommended in this handbook.

CHAPTER 7

ROUTINE SCREENING VERSUS SCREENING ONLY IN SUSPICIOUS CASES

Clinical practice points

- Quality of care hinges on the ability to detect the cause of a health problem.
- Early identification of suspected woman abuse may aid legal efforts to address the violence.
- Detection of cases of woman abuse can arise from either routine screening or screening only in suspicious cases.

Background

Several groups, including the American College of Obstetricians and Gynecologists[92] and the American Medical Association,[5,52,93] support routine screening of all female patients for woman abuse. Others suggest that the benefits of routine screening have not been assessed directly and favour greater efforts to detect it or recommend screening in suspicious cases.[29,84,94] Those who support routine screening argue that clinical signs of physical abuse can be subtle and if physicians are limited to asking only in suspicious cases, they might miss the subtle signs. It can also be argued that physicians vary in their degree of awareness and sensitivity about woman abuse and many do not become suspicious even when the signs are clearly visible.

The support for routine screening has mostly been through consensus and is based largely on the recognition of prevalence of the abuse and the number of undetected cases. Unfortunately, we do not have sufficient evidence that, in direct comparison, shows one method to be more effective than the other in terms of identification of cases, or the cost or quality of care. So far there is little evidence that routine screening will result in victims either divulging or confirming the abuse; that is, cases may be missed no matter what screening method is used. Finally, we know little about the preferences of most women about routine screening. One important study in a primary care setting examined patient preferences and physician practices about inquiry into victimization experiences.[79] Among the 164 patients surveyed (104 women, 60 men), 78% favoured routine screening about physical abuse (75% for women alone) and 58% favoured this practice for sexual abuse (63% for women alone). However, only 7% said they were ever asked about physical abuse and 6% about sexual assault. One third of the 27 physicians believed in routine screening. More research is needed on how patients feel about being routinely asked and whether they report that it influences the patient–doctor relationship, especially when the physician provides care to all family members.

Whichever approach is taken, Waller and colleagues[91] have suggested that the physician and the staff must believe in its utility and must be willing and able to use it as part of providing patient care. In a national study of 963 family physicians and general practitioners in Canada, approximately 98% surveyed believed they should be asking about the possibility of abuse when women present with suspicious injuries or with emotional difficulties.[28] Unfortunately, this study did not ask physicians whether they would routinely screen—making it impossible to determine physician preferences about routine screening.

At the very least, physicians should ask when they suspect the possibility of woman abuse. Obviously, a high degree of alertness is important. Chapter 2 describes the physical manifestations that should prompt physicians to suspect woman abuse and recommends when to suspect the possibility of woman abuse. However, there are other times when abuse should be suspected: a history of being "accident-prone"; implausible explanations of injuries; and simplistic, often vague, explanations of injuries.[95] Frequent somatic complaints should also prompt

suspicion.[37,96,97] These complaints may range from insomnia, depression, irritability and suicidal ideation to abdominal pain, pelvic pain, chest pain and headaches (Chapter 3).[37]

Recommendations

- There is strong consensus for routine screening; however, there is not enough evidence to fully support routine screening over screening in suspicious cases.
- Clinical judgement should govern which one is used, but using one of them is essential.
- If the physician decides to screen only in suspicious cases, it is imperative that he or she be alert when examining patients at increased risk of physical abuse and assess potential risk factors for violent injury.

Previous guidelines

All groups believe that it is crucial for physicians to maintain a high level of suspicion and question patients about abuse in suspected cases. Guidelines strongly favour routine screening,[52,58,90,98] rather than leaving the issue to a physician's discretion as we have recommended in this handbook. The American Medical Association[52] recommends routine screening of patients in emergency, surgical, primary care, pediatric, prenatal and mental health settings. The US Preventive Services Task Force[84] states that there is insufficient evidence to recommend using specific screening instruments. The Task Force also states that there is insufficient evidence to recommend for or against routine screening, but recommendations may be made on other grounds ("C" rating). Including a few direct questions about abuse may be recommended because of the prevalence of the problem, the potential value of this information for quality of care, and the low cost and low risk.[84] As well, the Task Force states that all physicians should be alert to physical and behavioural signs and symptoms associated with abuse. Others seem to lean toward screening in suspicious cases.[29,94] To date, research has not clearly established how most women feel about routine screening and whether physicians will incorporate it into their practices. What is clear is that physicians need to screen either routinely or in suspicious cases; one approach or the other is essential.

CHAPTER 8

DEALING WITH WOMEN WHO REMAIN IN ABUSIVE RELATIONSHIPS

Clinical practice points

- A woman may not leave an abusive relationship even after confirming that it exists.
- A woman may return to an abusive relationship after she has successfully left it.

Background

Some of the behaviours and coping strategies exhibited by abused women can at first be difficult to understand, and physicians often feel frustrated when women do not leave abusive relationships or leave only to return a short time later.[59,99,100] The phenomenon is common; for example, half the women who have been hospitalized for their injuries return home when they are discharged.[101] Yet there is an explanation for this seemingly unusual behaviour: studies show that women may be at increased risk if they try to leave an abusive relationship. Statistics Canada data[102] show that almost half the reported cases of murder of a woman in 1989 and 1990 occurred when the victim and her killer were in the process of negotiating a separation or divorce, and in 40% of cases when there had been a recent separation of residence. Analysis of the Statistics Canada data[102] suggests that separated couples are at greater risk than co-habiting couples for homicide—six-fold for women and three-fold for men.[4]

Why women stay in abusive relationships has already been partly discussed in Chapter 3. Women stay because they may be convinced that their husband or partner will change; they may feel responsible for the violence; or they may have been threatened with bodily harm or death if they try to leave. In addition, powerful social and economic factors dictate and limit the range of practical options available to many women.[103] Greaves, Heapy and Wylie[104] say that as the number of children increases, the likelihood of a woman leaving decreases. This is disturbing because children of abused women often suffer from psychological problems whether they experience the violence directly or only witness it. Jaffe et al.[64] found that boys exposed to violence between their parents have adjustment problems similar to those of children who were themselves abused. In another study,[105] the same researchers found that nearly 35% of the sons and 20% of the daughters of abused women had behavioural problems and retarded social skills. Mehta and Dandrea[20] found that men who abuse their wives are more likely than non-abusing men to assault their children as well. A Statistics Canada[42] survey on violence against women indicated support for the theory of a generational cycle of violence. The survey also revealed that women with violent fathers-in-law were three times as likely (36%) as women with non-violent fathers-in-law (12%) to be assaulted by their partners. Also, 39% of women in violent marriages reported that their children witnessed the violence against them.[42]

Based on the results of a questionnaire completed by 524 women in a battered women's clinic, Greaves, Heapy and Wylie[104] concluded that the relative measures of risk, not the absolute measures (be they economic loss, social or psychological, or threats of serious injury) have the greatest impact when a woman is assessing her options. Economic factors that may influence a woman to stay with her abusive partner include fear of reduced standard of living; having no money of her own or having no other affordable place to live; and a real or imagined inability to get a job.[106,107] It is imperative that a physician not make value judgements when a woman does not leave or when she returns, because such judgements can increase her sense of isolation and despair.[81] The goal of the office visit is not to get the woman to declare that she is going to leave her abuser, but to help her develop a sense of independence and self-worth that will lead her to ridding her life of abuse.[101] It is not possible for the physician to judge when it is safest to leave, and attempts to do so may not be helpful.

No matter how strong the fears for the patient's safety, the physician may not contact the police on behalf of the patient without her consent. It is certainly appropriate to advise an abused patient to contact the police and to offer to help her to do so if she wishes; however, it is the patient's right to refuse. Although it may be in the patient's best interest to cooperate with a police investigation, her right to confidentiality must be protected. Several jurisdictions in the United States have legislation requiring or permitting physicians to bring cases of woman abuse to the attention of the authorities with or without the victim's permission, but Canada does not. In Canada someone other than the victim is allowed to apply for a peace bond on behalf of the victim, but physicians should be aware that practice regulations do not allow them to do so without the woman's consent.

Recommendations

- Do not blame the victim or simplify the situation.
- Acknowledge personal feelings about dealing with a patient who is not leaving an abusive relationship or who is returning to it.
- Ensure that personal feelings do not interfere with the ability to deal effectively with the patient.
- Realize that it may take several discussions before a woman admits to herself that abuse is occurring.
- Do not aggressively counsel her to leave, but make sure she is aware of her options.
- Recognize and acknowledge the violence and express concern for her safety and well-being.
- Each time the opportunity arises, reinforce the concept that no one deserves to be assaulted and that it is not her fault.
- Provide her with educational material and information on community agencies and shelters (Chapter 14).
- Make appropriate referrals to counselling, community agencies and shelters (Chapter 14).
- Remain empathetic.

Other guidelines

Many groups have discussed the phenomenon of women remaining in abusive relationships, and several offer recommendations that are consistent with those listed here.[18,32]

CHAPTER 9

ASSAULTED WOMEN AND THE CANADIAN CRIMINAL JUSTICE SYSTEM

Clinical practice points

- If police are called, they may lay criminal charges if there are reasonable and probable grounds for believing that a crime has been committed, irrespective of the wishes of the victim.
- Police may encourage women to seek medical attention to treat the injuries and to obtain evidence of the crime.

Background

In 1983, the federal, provincial and territorial governments affirmed the criminality of woman abuse by issuing directives to police and Crown attorneys to lay charges when there are reasonable and probable grounds to believe that a criminal offence has been committed, irrespective of the wishes of the victim.[108]

Many immigrant and refugee women fear involvement with the justice system, perhaps because of experiences with police in their own country or fear of deportation. When immigration status is an issue, women need to know that their status in Canada will not automatically change as a result of any charges laid or actions taken, and that obtaining independent legal advice is essential. In a study of 64 Canadian women who spoke neither French nor English well enough to seek help, MacLeod and Shin[109] found that 44 (69%) had been abused by their husbands, and that there was a trend for the abuse to have either started or become worse after the couple immigrated. Whereas abuse usually increases in intensity, the trend of increasing violence for immigrant women in Canada may be related simply to the general epidemiology of abuse.

The laying of charges by police against abusive husbands reduces new incidents of violence. Burris and Jaffe[110] showed that police laying charges in London, Ontario, resulted in a significant decrease in charges being withdrawn or dismissed. Jaffe and colleagues[111] examined the impact of the directive to police to lay assault charges, and found a 25-fold increase in charges and an overall reduction in all forms of domestic violence in the following 12 months. In a U.S. study, Sherman and Berk[112] found that arresting an abusive partner was twice as effective as other police strategies (such as separating the couple and offering advice) in reducing victim-reported repeated violence over a six-month period.

A police officer who responds to a domestic violence call has the responsibility to restore order, investigate, gather evidence and protect victims. During the investigation, the police gather all relevant information, including statements from the victim and witnesses, medical reports, photographs and other evidence such as weapons that might have been used. In the event that the investigation demonstrates *reasonable and probable* grounds—that is, an ordinary, cautious and prudent person would be satisfied that facts or circumstances show a reason to believe beyond mere suspicion—that a crime has been committed, the officer may lay appropriate criminal charges. Police officers should not necessarily be influenced by any of the following:

- the marital status of the parties;
- the disposition of previous police calls involving the same parties;
- the victim's unwillingness to attend court proceedings or the officers' belief that she will not attend;
- oral assurances by either party that the violence will stop;
- denial by either party that the violence occurred when there is evidence that it did;

- concerns about reprisals against the victim by the suspect; and
- the race, ethnicity, sexual preference, social class or occupation of the victim.[113]

If criminal changes are laid, the officer prepares a summary of the case for the Crown Attorney—except in British Columbia, Quebec and New Brunswick, where police do not lay charges unless, and until, the Crown has approved it. The decision to arrest or to lay charges may be made independently of the complainant's wishes. Should the police choose not to charge, a private citizen can lay a charge if he or she can convince a Justice of the Peace that there are reasonable and probable grounds to believe that a crime has been committed. As well, if charges are not laid, the police, the victim or another person can apply for a peace bond under the *Criminal Code*, which requires the alleged offender to abide by stated conditions that usually involve having no contact with the victim.

Violations of the *Criminal Code* may result in one of two types of criminal charges: indictable offence or summary conviction offence. Some offences, called *hybrid offences*, can be prosecuted as either a summary conviction or an indictable offence. Summary offences include less serious crimes and generally carry a maximum penalty of $2,000 or 18 months' imprisonment. Indictable offences are more serious crimes and include assault causing bodily harm, aggravated sexual assault, attempted murder, and murder. With hybrid offences, the prosecutor will base the decision on how to proceed on the surrounding facts and circumstances of the crime, including the prior criminal record of the accused, if any; the seriousness of the allegations; and the time lapsed between the incident and the reporting of it. Specific criminal charges that may be laid in a case of woman abuse include:

- assault,
- criminal harassment,
- aggravated assault,
- assault causing bodily harm,
- sexual assault,
- aggravated sexual assault,
- sexual assault causing bodily harm,
- threatening to cause death or bodily harm,
- uttering threats,
- sexual assault with a weapon,
- intimidation,
- forcible confinement, and
- attempted murder and murder.

Other charges may include violation of a court order or breach of an order, bail, or probation condition. To charge someone with an offence, the police must only have reasonable and probable grounds. To convict an accused, however, the prosecution must prove the charges beyond a reasonable doubt.

While the police are responsible for investigating the crime and laying charges, the Attorney General's office is solely responsible for the conduct of the prosecution. Only the Crown can withdraw charges once they are laid. Most Crown attorneys' offices have the mandate to prosecute vigorously and consistently all cases of woman abuse, and a case may proceed in spite of the complainant's desire to withdraw the charges or refusal to testify.

Recommendations

- When documenting an assault, be aware that at some point there may be criminal charges laid and the physician's medical records might be used in a court of law.
- Provide the same support and empathy to women who wish to proceed with criminal charges as to those who do not.

Other guidelines

These guidelines are consistent with those of others.[29,114]

CHAPTER 10

PHYSICIANS AS WITNESSES IN CRIMINAL CASES

Clinical practice points

- Physicians may be asked to attend criminal court proceedings.
- Physicians need to be prepared and available for court appearances if necessary.

Background

The Canadian criminal justice system is charged with providing fairness to the accused while protecting the public interest. The process allows for the presentation and testing of evidence in court. In criminal proceedings, the Crown has the responsibility to prove the case against the accused beyond a reasonable doubt; any reasonable doubt must be resolved in favour of the accused.

During a criminal trial, the trier of fact (the judge or jury) decides what actually happened based upon the evidence presented. Rules of evidence determine what a court may consider when deciding the facts of a case. The evidence—be it documentary, real or demonstrative, or oral testimony—must be deemed legally relevant before it can be presented in court.[115] After determining the facts, the judge or jury must apply the law to the facts to determine the appropriate consequences.

Documentary evidence

Documentary evidence is any evidence in written form, including medical records, reports and sworn affidavits.[115] Traditionally, courts have been reluctant to allow medical records to be presented because documents were thought to infringe a fundamental principle of evidence law: the *hearsay rule*.[116] Hearsay rules prevent the judge or jury from considering out-of-court written or oral statements for the proof of their contents. For example, a physician's notation in a medical record that a patient was assaulted by her husband is not admissible in court to prove that the husband assaulted the patient; the victim herself must testify to that effect. The idea is that before any weight is given to a witness's evidence, the witness should be required to be present in court to testify under oath or its equivalent and to have his or her evidence tested in cross-examination by the opposing party. The main reason for the exclusion of hearsay is the absence of the opportunity to challenge the evidence through cross-examination.[117,118] The judge or jury should also have the opportunity to observe the witness to decide what weight, if any, should be given to this person's evidence.

However, there are many exceptions to the hearsay rule. In most provinces, statutes have made medical records from hospitals and doctors' offices admissible as evidence in court, provided that they were made in the *usual course of business*[116]—that is, in the course of everyday medical or hospital practise. A medical report authored by a qualified physician can generally be admitted as evidence without the physician being present in court.[119,120] The Supreme Court has ruled that a medical record may be viewed as *prima facie* proof of the facts stated in it.[116] However, where the factual assertions in the medical record are contentious or where the opposing party insists on the right to cross-examination, the physician may be called to testify.

Oral testimony

Oral testimony (*viva voce* evidence) refers to evidence given orally under oath or its equivalent by witnesses who testify on the witness stand.[115] The evidence presented by a witness must generally be on matters that he or she has directly witnessed, experienced or has direct knowledge of. Physicians may be called as witnesses in cases of woman abuse by either the defence or the Crown. For practical purposes, the physician is most likely to be called as a witness by the prosecution to corroborate the allegations of the assault. In some cases, the lawyer for

the accused may seek to call the physician in an attempt to undermine the credibility of the complainant or to demonstrate contradictions in various versions of the incident.

Physicians as witnesses

Courts expect a high degree of competence and medical expertise when physicians testify.[121] Physicians are not in court to assist either side but to give evidence impartially, honestly, fairly and moderately.[121,122] In essence, expert witnesses are there to assist the court, not the party who called them.[122] Predictably, lawyers will focus on aspects of the expert's testimony that may be favourable to their clients.[121]

If a physician is called to testify, it will usually be for one of the following reasons:

- *To provide evidence of physical injuries*

The medical practitioner may be asked to give testimony about events surrounding the evaluation and treatment of a patient. In such cases, physicians will be required to testify only about matters that they have directly observed and with which they are personally familiar.[115] Evidence, including documentation of the physical examination and treatment, photographs and diagrams, might be used to corroborate or confirm allegations of abuse or to prove the nature and extent of the injuries and the degree of pain suffered by the patient.

- *To provide a history of an abusive relationship*

Medical evidence of previous abuse may be admitted, pursuant to rules of evidence, permitting the prosecution to prove criminal intent or motive, to provide narrative or context to the specific allegations before the court or to rebut the defence of accident or good character. Furthermore, evidence showing a history of abusive behaviour may be relevant to issues of sentence if the accused is convicted. Obviously, if the incident of abuse is not isolated but forms part of a pattern of abusive conduct, it will be treated more seriously and attract more onerous consequences.

- *To give an expert opinion*

Although a witness generally is not entitled to express an opinion or conclusion about the facts in issue, one who has been established to be an *expert* as a result of training or experience, such as a doctor licensed to practise medicine, may be able to offer an opinion.[123] For example, a physician may be able to explain how the injuries were caused. Before being permitted to give an opinion, the witness must be *qualified* as an expert in the area on which his or her opinion is sought.[124] Typical expert opinions elicited from physicians treating woman abuse victims include whether an injury is consistent or inconsistent with the application of deliberate force (e.g., the pattern of injuries may rule out an accident); the type of assault (e.g., whether a weapon was used); the degree of force exercised; or the age of the injury.

Expert medical evidence might also be called to explain battered woman's syndrome— that is, to explain why a woman may have tolerated many incidents of abuse before reporting them, or stayed with her abuser, or recanted her allegations.[125]

- *To prove contradictory statements*

A new exception to the hearsay law allows that if a woman tells her doctor that she was assaulted by her spouse and then later recants her allegations at trial, the prosecution may seek to have her original statement admitted in court. Unadopted out-of-court statements— that is, out-of-court statements that the person subsequently denies in court—are admissible if they are *necessary and reliable* to prove a fact in issue.[126,127] The legal prerequisites for admitting contradictory out-of-court statements in this way are relatively onerous, so the prosecution will not attempt to do so in every case of recantation. However, recantations in woman abuse cases are common, and so the change in the law is important for prosecutors and may provide a way of proving charges when there has been a recantation.[128]

Contradictory versions of the allegations may also be used by the defence in an attempt to undermine the victim's credibility. If the complainant's testimony at trial is different from the account given to the physician, the defence will argue that the complainant should not be believed because she is untrustworthy or her recollection is unreliable. To avoid an unfair challenge to the complainant's credibility, it is critical that physicians accurately and carefully record the patient's account of the abuse. However, such challenges to the complainant's credibility would not happen very often because it is debatable whether statements recorded in doctors' notes meet the legal criteria for *prior statements* upon which a witness may be cross-examined.

Recommendations

- A physician asked to be a witness should consider asking for pre-trial preparation by the lawyer.
- Know the facts of the case well.
- Before the court proceedings, do not seek clarification of the facts of the case from the woman or discuss them with her; this could compromise the integrity of the evidence and the independence of the witnesses.
- Listen carefully to the questions being asked.
- Bring a copy of the medical documentation to court.
- Answer all questions impartially and honestly.
- If the answer is not known, say so.
- Remember, the physician is there to assist the court, not either of the parties.

Other guidelines

These guidelines are consistent with previous ones in this area.[29,52]

CHAPTER 11

CONFIDENTIALITY AND DISCLOSURE TO POLICE AND TO COURTS

Clinical practice point

- Physicians need to know when they must keep information confidential and when they are required by law to divulge it.

Background

During the investigation of an alleged crime, police officers may request information from a physician about care or services rendered to an alleged victim. Although it is an offence to willfully obstruct police officers in the execution of their duty, police officers have no absolute right to the information contained in a medical record even when it is necessary for their investigation. Similarly, a lawyer's letter demanding production of medical documentation is not sufficient authority to release it. Physicians are required to keep confidential any information derived from a patient or from a colleague regarding a patient, and to divulge it only with the patient's consent, unless otherwise required by law.[129] The most important consideration is not to mislead police or provide false information, as this could be seen as a criminal offence (obstructing justice). A physician asked by police for medical documentation should respond simply that a consent form from the patient is first required. In the absence of consent, a physician is required to release medical information only if the police have a search warrant, subpoena, summons or other court order.[130]

Consent is valid only when given voluntarily by a fully informed person,[115] and must not be obtained as a direct result of coercion or duress. The consent form should clearly state the specific nature of the information being shared, and with whom and for what purposes it will be shared. The patient's signature should be witnessed and dated. It is important that she understand that the Crown attorney is obliged to disclose all relevant information to the accused party;[131] therefore, once the police obtain the medical record, the accused and his attorney will also be permitted to review its contents.

In a criminal proceeding, the most common method for the courts to obtain medical documentation about patients who do not consent to its release is a subpoena, which compels a witness to attend a proceeding on a given date. A subpoena may also require a witness to bring to court certain records or documentation in his or her possession. Even when a subpoena is received, the documents should not be simply handed over to the lawyer demanding them, but should be released only in court by the order of the presiding judge. A physician who is requested to bring documentation to court should photocopy the material to ensure that a complete copy of the records is available.

There are serious consequences for failing to comply with a subpoena, and a physician who fails to attend court as required may face arrest or contempt of court charges. Once ordered by a court to disclose confidential patient information, a physician cannot refuse to answer questions on the grounds of patient-doctor confidentiality or because the patient objects. In Canadian courts, information between a physician and his or her patient is compellable in court.[132]

Recommendations

- If asked by the police for information, the physician should inform them that he or she is not professionally able to divulge information without the patient's written consent.
- Have a written release form available in case a patient wishes to have her records released.
- If in doubt about legal obligations, contact the provincial or territorial medical licensing authority or medical association, a private solicitor or legal defence association.

Other guidelines

These guidelines are consistent with those of others.[18,29]

CHAPTER 12

VIOLENCE IN THE MEDICAL SETTING

Clinical practice points

- Physicians who are themselves victims of threats, assaults or other crimes are not expected to maintain patient confidentiality about such offences.
- Physicians need to know their legal rights and the rights of their office staff on the matter of dealing with actual or threatened violence.
- There are measures that can be taken to reduce risk of violence in the medical setting.

Background

In Canada, it is believed to be uncommon for physicians who treat abused women to be themselves threatened or harmed by the abuser, and no studies deal specifically with this issue. A few U.S. authors, however, have suggested that front-line health care professionals are at risk when they are called upon to manage both the victim and the perpetrator.[133,134]

Physicians have the same legal rights as any other person who is threatened or harmed, whether or not the perpetrator is their own patient. It is not a breach of patient confidentiality to report such offences and to seek criminal prosecution.

For physicians who are concerned, the safety and security of the workplace can be strengthened by the following measures.

Reporting and reviewing incidents of workplace violence

All hospitals and clinics should have incident-reporting forms for documenting any threats or aggressive acts on their premises. Administrators and executives should establish workplace models that include the definition, assessment, and management of threatening and dangerous behaviour. Hospitals that fail to meet acceptable standards of security could be held liable for violent acts committed on their premises.

Management of workplace violence

All hospitals should have a policy on what to do if a violent situation occurs. The plans should be rehearsed, and there should be routine reviews of the security measures. Physicians should be educated on conflict resolution and what to do in case of violence. Emergency protocols should be developed and, if violence occurs, followed.

Security department

The hospital should establish security policies on issues such as weapons and aggressors. There should be no tolerance of weapons, and the hospital should have the resources and protocols to be able to stop a violent person. As well, health care providers must remain alert to the signs of an aggressive person, such as anger or agitation, and notify security immediately.

- *Physical setting*: The physical setting of the doctor's office, such as an unpleasant waiting room environment, may be conducive to violence. Long waiting times under stressful circumstances have also been associated with violence. Furthermore, the attitudes of the office staff can be significant: brusque, argumentative or officious staff can easily anger patients and push violence-prone persons "over the edge."[135] Accordingly, it is important to train and offer periodic refresher courses to all staff on how to recognize and defuse violence.
- *Safer working practices*: Numerous common sense precautions need to be followed in order to remain alert to the potential for violence and to minimize the

chance of experiencing it. For instance, when dealing with a potentially violent patient, physicians should first remove any stethoscope, jewellery, necktie, pens and other items that may be used as a weapon; they should never turn their back on the person, and should always leave an exit clear.

Recommendations

- Remember that physicians have the same legal rights to safety as others.
- When threatened or feeling unsafe, consider calling the police.
- Ask if the hospital or clinic has protocols for managing potentially violent situations and, if so, be familiar with them and post them for other office staff.
- If the hospital or clinic does not have such protocols, ask that it create them.

Other guidelines

The issue of a physician's safety when dealing with domestic violence has received little attention because it is not prevalent; therefore, no other current guidelines exist.

CHAPTER 13

IMMEDIATE ACTIONS AFTER IDENTIFICATION: RISK ASSESSMENTS AND SAFETY PLANNING

Clinical practice points

- Conducting a risk assessment for domestic homicide is an essential clinical intervention.
- A safety plan needs to be devised before the woman leaves the medical setting.

Background

Once an abusive situation has been identified, the physician must immediately address two major issues: assessing the risk to the woman and devising a plan for her safety. Risk assessment involves asking a series of questions to determine whether the patient may be in imminent danger. Several risk assessment tools deal with the potential for domestic homicide.[136-139] Ferris, McMain, and Silver[29] summarized published tools, and suggested posing the following questions in language appropriate for the patient:

- Have weapons been used, or has there been a threat to use them?
- Is there access to, or ownership of, firearms?
- Have there been threats to kill?
- Does the violence appear to be escalating or occurring more frequently?
- Has there been destruction of property?
- Has there been forced sex?
- Has there been a threat of injury to the woman or a threat to kill a pet?
- Is there a history of psychological problems?
- Is there an obsessiveness to the partner? Does he manifest extreme jealousy?
- Is there alcohol or drug abuse?
- Has there been any recent significant change to the marital situation, such as a separation or threat of separation, a pregnancy, a job loss or a change in financial circumstances (all of which, the literature suggests, may be prompters for increased violence)?

The more of these questions that are answered affirmatively, the more imminent the danger to the woman. However, *any* time the physician knows or strongly suspects that violence has occurred, it is best to err on the side of caution and overestimate rather than underestimate the risk. If the patient confirms the abuse, then devising a safety plan is the minimum intervention a physician should follow.[29,101]

A safety plan is a key element in the care of an abused patient, and should be individualized and constructed with her collaboration.[52,81,100,140,141] The plan is especially important when the woman is considering leaving the abusive situation, because this is often the most dangerous time for her.[81,100]

If there is immediate risk, the focus should be on finding a safe place for her to go, such as a battered women's shelter or other emergency housing in the community. If the woman decides to return to her partner, a plan for her safety needs to be formulated. The components may vary, but all plans should include a viable strategy for dealing with an emergency. Examples of components of a safety plan include the following:[29]

- telephone numbers for emergency assistance (e.g., 911) and for family, friends, police, hospitals, shelters and help lines; the woman must be aware that domestic assault is a crime and that the police are available 24 hours a day;

- the location of nearby shelters;
- information about educational services on woman abuse along with their addresses and telephone numbers (including language and ethno-specific services if necessary);
- information about legal or lawyer referral services, including telephone numbers;
- information about legal rights (protective measures available to her, support and custody issues) and immigration rights; and
- information on how to plan an emergency escape route.

Others suggest that women be given information about what to pack in an emergency bag. Items could include bank books and bank account numbers; a marriage certificate or prenuptial contract, birth certificates, passports, health insurance cards, insurance policies, health and vaccination records for herself and any children; a driver's licence; a social insurance card; educational diplomas or professional certificates; regularly taken medications and prescriptions, and special toys for the children.[61] The bag should be left with a trusted friend whose house can serve as a place for her to go to the next time she is assaulted. All these items may be needed, but a woman needs to decide what she can realistically pack away, as she will not have ready, daily access to them.

The American Medical Association[52] highlights the importance of validating the woman's experience and confirming that she has made the right decision by revealing the problem. Giving her data on the prevalence of woman abuse may help her realize that she is not alone. Also, reinforcing the concept that no one deserves the treatment she is enduring is valuable.

A difficult and serious issue is the appropriate management of a patient who does not acknowledge being abused in spite of strong evidence that violence is occurring and may be escalating. What should a physician do when there is reason to believe that the patient is clearly in danger? In their work with a consensus panel, Ferris and colleagues reported two options. First, the physician could consider introducing the topic to the woman by discussing her injuries and mentioning that *if* they were the result of abuse, information about safety could be provided to her. A hypothetical safety plan could still be formulated and presented to the patient. However, taking this approach will depend on the situation and the physician's comfort level and perception of the patient's receptiveness. The second option is to provide her with general educational material on various health issues, including domestic abuse. This gives her an opportunity to become more informed about the prevalence of domestic violence, may help to reduce her perception of guilt and shame and her sense of helplessness and dependency, and may increase the likelihood of her seeking assistance.

Being aware of the societal resources for protection and aid, whether or not she actually takes advantage of them, may expand the patient's perception of available alternatives and alleviate the sense of isolation and entrapment reported by so many abused women.[142] A chronically abused woman cannot be expected to be able to gain overnight the self-esteem, self-reliance, emotional support and financial stability required to overcome her situation.[101]

Recommendations

- Be knowledgeable about the epidemiology of woman abuse in order to provide important information to the patient.
- Inform her that the abuse is a criminal offence and that the police will take her complaints seriously.
- Assess the woman's immediate safety by using a risk assessment tool.
- Be aware of the markers for imminent danger (e.g., weapon in the home, alcohol abuse, previous violence, escalating levels of violence, separation).
- Validate the woman's experience and show a willingness to listen.
- Be knowledgeable about community resources available to ensure her safety (Chapter 14).
- If there is immediate risk, focus on helping her find a women's shelter or other emergency housing in the community.
- Advise a woman who fears for her safety that she should call 911 at any time (provided she is in an area with this service).

Other guidelines

These guidelines are consistent with others.[29,52,56]

CHAPTER 14

IMMEDIATE CONCERNS AFTER IDENTIFICATION: FOLLOW-UP AND REFERRALS

Clinical practice points

- Legal efforts to address woman abuse may be aided by a physician who identifies the crime and provides the victim with information about community resources, including police and legal services.
- Making appropriate referrals may increase the likelihood that the violence will end.

Background

Canadian studies on the medical profession's response to woman abuse show that family physicians and general practitioners believe they ought to be involved in detecting and managing the problem.[27, 28] Whenever a patient discloses abuse, her physician should respond by validating her experiences and assuring her that this information will be kept confidential.[5,18,52,53,81,100,143]

Physicians are consistently warned against blaming the victim or attempting to simplify the situation by asking such questions as, "Why don't you just leave?"[18,52,91,144] It is not advisable to try to rescue the woman or to aggressively counsel her to leave, as leaving may heighten her risk.[37,81,145] Only the woman herself can judge when leaving may be safest.[99,146] However, as staying in the abusive relationship is also risky, it may be best to provide her with information on community services and to make referrals so that she can have a plan in place for when she feels she can leave.

Immediate intervention should include referrals to appropriate services and resources, including other professionals.[18,29,37,52,53,81,89,91,140,141,144] However, referrals should not necessarily end the physician's own involvement with the problem. Hansen and colleagues[147] surveyed 715 primary care patients to determine their interest in having their family physicians help them with four representative psychosocial problems, including woman abuse or neglect, and found that 57% to 78% wanted help from their family physicians either independently or with a specialist; only 4% to 21% wanted referrals to specialists exclusively. When making referrals, the family physician should ensure that the patient is not shunted from one source to another[83] and that there is routine follow-up afterward.[29]

There are good reasons for providing information and referrals. In a study of 67 abused women who were offered a listing of community resources for victims of violence, McFarlane and colleagues[148] found that use of these resources was significantly related to the severity of the abuse. One year later the women were still accessing these resources. This suggests that abused women will follow through with referrals and will maintain contact with the community agencies. Other researchers have found that the quality of medical care a women receives will predict whether she will follow through with referrals to health care agencies and to legal and social services.[105,149]

Several groups stress the importance of discussing the problem with the woman in conditions of privacy and safety, and of not discussing it with any third party, including the abusive partner, without her prior consent.[29,52] However, as noted in Chapter 6, private interviewing of women who do not speak English or French may be difficult. If abuse is suspected but a language barrier prevents its discussion, the physician might consider calling community health centres or agencies to ask if they know of any local doctors who speak the patient's language.

Follow-up appointments

Brown, Lent and Sas,[150] in focus groups with 32 Canadian physicians, found that physicians thought that follow-up appointments were a good way to manage patients suspected or known to be victims of wife abuse. The physicians thought that the initial appointment was a good

time to plant the seeds for future discussion, especially if disclosure was not forthcoming, and that follow-up appointments were important. The follow-up appointment offers the physician a way to help ensure the patient's safety, confirm a diagnosis and offer treatment.[37,89,140,141,150]

Providing information

According to Alpert,[51] "just as in the case of cancer, physicians should provide patients with information about available options and resources." As with any other medical condition, it is important that the patient learn about the problem and about her options. Providing her with information allows her to seek assistance in her own time, and enables her to turn to alternative resources if she is uncomfortable discussing the issue with her physician.[18,37,52,89,100]

Abused women will need information about shelters and community services, and physicians should consider providing them with information about the potential for police involvement. As described in Chapter 9, all provincial and territorial governments have affirmed the criminality of woman abuse and knowing this may make it more likely the patient will call the police. However, as pointed out in Chapter 11, physicians should not contact police on behalf of the patient without her permission.

Counselling

The use of couple counselling for treating domestic violence is controversial[63, 99] and generally thought to be contra-indicated.[18,29,52,63,81,91] The American Medical Association[52] states that traditional marital therapy can lead to an escalation of violence. Ferris and colleagues[29] state that it is generally not advisable to conduct joint counselling, which rests on the assumption that both parties are equal—which is not the case in abusive relationships. If joint counselling is considered, physicians should provide it only if they are highly expert and confident that they can counsel sessions without risking escalation of violence, and only after the violence has ended.[29]

Treatment for the abusing man should also be considered[141] as treatment and services provided to the woman cannot change the man's behaviour.[151] Reviews of treatment goals for batterers agree that one of the most important goals to be achieved by the male in treatment is taking responsibility for the violence.[151-155]

Recommendations

- Be knowledgeable about community agencies and shelters, the services they offer, the languages spoken and the referral process.
- Provide relevant information to the patient about community agencies and shelters.
- If appropriate, make a referral to another professional, and always routinely follow up with the patient about the referral made.
- Whenever possible, meet with the patient in private.
- If abuse is suspected but a language barrier prevents its discussion, consider referring the patient to a physician who speaks her language.
- Keep the information provided by the patient confidential.

Other guidelines

These guidelines are consistent with those of others.[29, 52]

CHAPTER 15

WORKING TOWARD A TEAM APPROACH TO DEALING WITH WOMAN ABUSE

Clinical practice points

- Physicians are just one group of many in the health, social service, and legal fields dealing with woman abuse.
- A team approach is needed to deal with the problem.

Background

Physicians are in a unique position to interact with victims of wife abuse when they seek medical treatment for physical injuries, psychological distress or somatic complaints.[29] Often a physician is the first health care professional to whom an abused woman turns for help.[52] Accordingly, there is tremendous responsibility placed upon physicians to identify cases, provide emotional support, treat the injuries and inform patients about the community resources available to them.

Nevertheless, the responsibility for dealing with abused women does not lie with physicians alone. Transition houses and other emergency shelters, police and legal services, children's aid societies, mental health professionals, community support groups, victims' advocacy groups and other health care providers are integral members of the response network. It is imperative that there be recognition and coordination among these various groups and services, and that physicians be aware of how to support and participate effectively in an interdisciplinary approach.

Established shelters are available in many communities. In addition to serving as emergency housing, these facilities offer support in a variety of forms and enable victims to connect with other women in the shelters.

Counselling is an essential element of follow-up care. Its thrust is to reassure the woman that she is not alone, to help her to accept that no person deserves to be beaten, and to inform her that controlling the violence is the responsibility of the batterer.[156] The role of the counsellor is to contribute to the diagnosis of assault, to assist in the communication process among family, medical staff and outside agencies, to provide the woman with information about her options and about the legal process, and to assist in follow-up referrals.[76] Through this process, counselling helps the assaulted woman restore her self-esteem and supports her independent planning for the future. Its overall therapeutic goals are to help the patient accept her ambivalence, clarify her feelings and identify her alternatives. Achieving these goals requires the use of many community resources.

Many abused women lose their networks as a result of the isolation they experience. Physicians need to be aware of the resources available and, as patient advocates, help assaulted women gain access to these resources where appropriate. Numerous grass-roots organizations serve as social support networks, offering a variety of supports, including peer-supported discussion groups, legal advocacy, counselling and referral services. These informal networks offer the abused woman an opportunity to validate her experiences with other victims, express her anxieties and concerns, and receive advice about resources. Through strengthening her contacts with members of the community, the networks can serve as a stepping-stone when planning a recourse.

Police and legal services play a different important role. As mentioned in Chapter 9, the laying of charges and the prosecution of a criminal offence may assist in preventing the violence from re-occurring. Providing the patient with information about police and legal services is important.

Recommendations

- Provide expert medical services to abused women.
- Recognize the importance of other health, social and legal services, and know how to access them.
- Through collaboration, work with community service providers to offer optimum care to abused women.

Other guidelines

Several guidelines discuss the importance of knowing community resources.[52,53,91,157,158] The Working Paper by the Public Expectations Working Group, Survivors of Violence Against Women[158] also emphasizes the importance of collaborating effectively with a broad range of services, working effectively in health teams and developing further referral skills.

CHAPTER 16

MANAGING WOMAN ABUSE WHEN BOTH PARTNERS HAVE THE SAME PHYSICIAN

Clinical practice points

- Physicians may have both the male and female partner in their practice.
- It is important to know how to deal with both partners in these circumstances.

Background

It is possible that both the victim and the offender have the same physician, and it may be difficult for the physician to know how to provide high-quality care to both patients. Surprisingly, there is little relevant information available to physicians.

In 1997, the first set of guidelines[159] for physicians dealing with these so-called dual relationships clearly stated that it is not a conflict of interest for the physician to deal with the abused female partner when both partners are patients. Both patients have a right to autonomy, confidentiality, honesty and high-quality care.

Physicians, however, need to be aware whether they practise in an area that permits or requires a *duty to warn/inform*, which, by definition, occurs when a patient makes a serious threat of harm to others and there is a serious potential for violence. If the duty is present, physicians need to know the circumstances in which it arises, how to execute it and to whom to report it. No province in Canada currently has any legislation requiring physicians to inform or warn when patients threaten serious harm to others and there are reasonable grounds to believe that the violence will occur. However, Canadian common law suggests that physicians currently do have such a duty to protect the public by informing or warning. Physicians who have a patient who makes a serious threat of harm to others should contact their medical defence association, private solicitor or medical association for clarification. In a precedent-setting document, Ontario's Medical Expert Panel on Duty to Inform recommended that the province's *Medicine Act* be changed to reflect a mandatory duty to inform when a patient makes a serious threat of violence and it is more likely than not that the violence will occur.[160-162] The recommendations of the Panel are currently being implemented in Ontario. Those practising in Ontario are encouraged to call their college or medical legal defence for directions.

The Panel recommended that physicians deal with each patient independently and that they not discuss the possibility of abuse with the male partner without the consent of the abused female partner. Referring one or both partners to another qualified physician was preferred if a physician feels unable to deal effectively with either patient because of this dual relationship.

Recommendations

The following recommendations are from L. E. Ferris, P. G. Norton, E. V. Dunn, E. H. Gort, and N. F. Degani with the Delphi Panel and the Consulting Group. Guidelines for managing domestic abuse when male and female partners are patients of the same physician. *Journal of the American Medical Association* 1997; 278(1): 851–857.[159]

General comments

- If a physician does not feel confident in dealing with abuse or the possibility of it, or feels that his or her judgement is affected by a personal bias or by the existence of the dual relationship, an offer of referral is appropriate.
- It is not a conflict of interest to ask a woman about the possibility of abuse or to have an active management plan when abuse is suspected or confirmed and the male partner is also a patient.
- The needs of female and male patients should be addressed independently such that their rights to

autonomy, confidentiality, honesty and high-quality care are maintained.

- Reference to the possibility of abuse or confirmation of it, based on the assessment of the female, should not be noted in the medical chart of the male partner.
- Information gained from the male partner about the abuse should not be recorded in the medical record of the female patient.
- Posters, pamphlets and other information about wife abuse for both male and female audiences should be in the waiting rooms, washrooms and examination rooms.
- When abuse is suspected or confirmed, a woman should be interviewed without the male partner present.
- Physicians need to know and act accordingly if they practise in a jurisdiction where they are required (or permitted) by law to report cases in which there is a threat of serious harm.

Confidentiality

- The first action when dealing with abuse is to affirm to the woman that her health and safety are important and that her confidentiality will be protected, unless disclosure is required by law.
- There should be no discussion about the suspected or confirmed abuse with the male partner unless the woman consents to it.
- If there is a discussion with the male partner about the abuse, the content of that discussion should not be shared with the woman unless the male consents to it.
- Office staff should not leave messages about appointment times, tests, or results with partners or on home answering machines. A woman who has not yet confirmed abuse may agree to having physicians or their office staff leave information about test results, appointment times, etc., on her home answering machine because she does not want to say why she would actually prefer this not be done.

Recognizing and managing abuse

- When abuse is suspected or confirmed (and there is no conflict of interest in cases of dual relationships) it is important to determine the risk to safety, as this will guide the discussion about how to proceed.
- It is important when conducting an assessment of the risk to safety that a physician is not influenced by information he or she has about the male partner; it is easier to respond to the magnitude and severity of the injuries when the woman is dealt with independently.
- If a woman agrees to the physician contacting the male partner, it is important that a safety plan be in place as her disclosure of the abuse may put her at risk of retaliation if the male is confronted.
- With the woman's permission, a physician may introduce the topic of abuse with the male partner. A previously scheduled patient visit is the best time to act on this plan. It is unclear whether initiating contact with the male partner is appropriate.
- If both partners are patients, offering individual counselling is appropriate, provided that the physician is trained to deal with violence. Offering a referral is also appropriate.
- It is generally inadvisable to attempt joint or marital counselling, and this should be attempted only if the violence has ended. Physicians must have a high level of expertise and confidence that they can conduct such counselling without escalating the violence, and they must have training specific to dealing with violent relationships.
- The possibility of joint or marital counselling should be raised with the woman first without the male partner knowing it is a possibility. Some abused women are so controlled by their abusive partners that they may consent because of pressure from, or fear of, the partner.

Other guidelines

To date there is only one set of guidelines that deal with this issue specifically.[159] The recommendations reported here are consistent with those published guidelines.

APPENDIX

SUMMARY OF RECOMMENDATIONS

Chapter 2: Physical Manifestations of Woman Abuse

- Strongly consider woman abuse when the injuries sustained do not fit the history given.
- Watch for evidence of previous injuries or injuries that are at different stages of healing.
- Be aware of the common sites for injuries (e.g., head, neck, face, throat, chest, abdomen) and clusters of multiple injuries.
- When performing a physical examination, visually examine under the patient's gown for injuries to the ribs, breasts, groin and other body parts covered by clothing.
- Watch for injuries to bone or soft tissues, including lacerations to head or face; broken teeth; fractured or dislocated jaw; contusions; abrasions; pulled-out hair; black eyes; perforated eardrums; burns and scalds caused by cigarettes, hot grease, stove elements and acids; fractures of clavicle or ribs; strangulation marks; internal injuries; bite marks; retinal hemorrhage; and evidence of sexual assault.
- Consider the possibility of violence when there have been multiple visits to an emergency department.
- Gunshot and stabbing wounds are strongly linked to woman abuse and should be treated as highly suspicious unless there is strong evidence to suggest the attack was not by a partner.
- Watch for signs of sexual assault.

Chapter 3: Psychological Manifestations of Woman Abuse

- Consider the possibility of psychological abuse (with or without accompanying physical violence) when there is:
  - fear of, or anger toward, the male partner;
  - stress; post-traumatic stress disorder; other anxiety disorders or depression (e.g., sleep and appetite disturbances; fatigue; chronic headaches; reports of severe crying spells or feelings of isolation; suicidal thoughts; acute anxiety attacks; chronic pain without identifiable cause; headaches; pain in the back; chest or stomach; gastrointestinal and abdominal complaints; palpitations; dizziness; paresthesias; dyspnea);
  - frequent occurrence of gynecologic problems, pelvic pain; and
  - frequent or long-term use of prescribed minor tranquilizers, pain medications, or psychoactive drugs.
- Help the patient to recognize the range of abusive behaviours she is enduring and let her know that she does not deserve this treatment.
- Consider the possibility of abuse when there is a history of suicide attempts, long-term use of psychoactive drugs, history of psychiatric illness, or substance abuse.
- Be highly suspicious of physical abuse and watch for it routinely.

Chapter 4: The Role of Medical Documentation in Providing High-Quality Care and in Legal Proceedings

- Include in the medical documentation of woman abuse:
  - the medical history;
  - the patient's chief complaint (verbatim);
  - a description of the abusive event (verbatim);
  - a detailed description of injuries, including type of injury, location (in relationship to fixed landmarks and standard anatomical regions), length, width, shape, colour and depth;
  - laboratory and other diagnostic test findings;
  - diagnosis;
  - medical treatment provided; and
  - photographs, if taken.
- Carefully document what clinical specimens were collected and to whom they were transferred (Chapter 5).
- In suspected cases of abuse, consider keeping medical records for longer than usual because there is no way of knowing when or whether they may be required in a criminal case.
- Do not transfer a medical record to another physician: instead, consider sending, with the patient's written permission, a summary of the pertinent information contained in the record to the other physician.

Chapter 5: Preserving Evidence

- Know what evidence may be needed for court proceedings.
- Know the legal protocol for collecting and preserving evidence for court.
- If you are in doubt, contact your medical association, college, legal defence association or private solicitor.
- If police are involved, have the appropriate telephone number available in case you need to ask questions or obtain advice about collecting and preserving evidence.

Chapter 6: Asking a Patient About the Possibility of Woman Abuse

- Be alert to suspect woman abuse.
- Ask simple questions.
- Use clinical judgement to decide whether direct or indirect questions will be asked.
- If children are in the home, ask questions about whether they are being abused.
- Be empathetic.
- Be non-judgemental.
- Interview the woman alone, if possible, and in a confidential setting.
- Make an opening supportive statement (e.g., "I am concerned about your injuries.").
- Advise the patient that information will be kept confidential unless there is a legal requirement to disclose it.

Chapter 7: Routine Screening Versus Screening Only in Suspicious Cases

- There is strong consensus for routine screening; however, there is not enough evidence to fully support routine screening over screening in suspicious cases.
- Clinical judgement should govern which one is used, but using one of them is essential.
- If the physician decides to screen only in suspicious cases, it is imperative that he or she be alert when examining patients at increased risk of physical abuse and assess potential risk factors for violent injury.

Chapter 8: Dealing with Women Who Remain in Abusive Relationships

- Do not blame the victim or simplify the situation.
- Acknowledge personal feelings about dealing with a patient who is not leaving an abusive relationship or who is returning to it.
- Ensure that personal feelings do not interfere with the ability to deal effectively with the patient.
- Realize that it may take several discussions before a woman admits to herself that abuse is occurring.
- Do not aggressively counsel her to leave, but make sure she is aware of her options.
- Recognize and acknowledge the violence and express concern for her safety and well-being.
- Each time the opportunity arises, reinforce the concept that no one deserves to be assaulted and that it is not her fault.
- Provide her with educational material and information on community agencies and shelters (Chapter 14).
- Make appropriate referrals to counselling, community agencies and shelters (Chapter 14).
- Remain empathetic.

Chapter 9: Assaulted Women and the Canadian Criminal Justice System

- When documenting an assault, be aware that at some point there may be criminal charges laid and the physician's medical records might be used in a court of law.
- Provide the same support and empathy to women who wish to proceed with criminal charges as to those who do not.

Chapter 10: Physicians as Witnesses in Criminal Cases

- A physician asked to be a witness should consider asking for pre-trial preparation by the lawyer.
- Know the facts of the case well.
- Before the court proceedings, do not seek clarification of the facts of the case from the woman or discuss them with her; this may cor ıpromise the integrity of the evidence and the independence of the witnesses.
- Listen carefully to the questions being asked.
- Bring a copy of the medical documentation to court.
- Answer all questions impartially and honestly.
- If the answer is not known, say so.
- Remember, the physician is there to assist the court, not either of the parties.

Chapter 11: Confidentiality and Disclosure to Police and to Courts

- If asked by the police for information, the physician should inform them that he or she is not professionally able to divulge information without the patient's written consent.
- Have a written release form available in case a patient wishes to have her records released.
- If in doubt about legal obligations, contact the provincial or territorial medical licensing authority or medical association, a private solicitor or legal defence association.

Chapter 12: Violence in the Medical Setting

- Remember that physicians have the same legal rights to safety as others.
- When threatened or feeling unsafe, consider calling the police.

- Ask if the hospital or clinic has protocols for managing potentially violent situations and, if so, be familiar with them and post them for other office staff.
- If the hospital or clinic does not have such protocols, ask that it create them.

Chapter 13: Immediate Actions After Identification: Risk Assessments and Safety Planning

- Be knowledgeable about the epidemiology of woman abuse in order to provide important information to the patient.
- Inform her that the abuse is a criminal offence and that the police will take her complaints seriously.
- Assess the woman's immediate safety by using a risk assessment tool.
- Be aware of the markers for imminent danger (e.g., weapon in the home, alcohol abuse, previous violence, escalating levels of violence, separation).
- Validate the woman's experience and show a willingness to listen.
- Be knowledgeable about community resources available to ensure her safety (Chapter 14).
- If there is immediate risk, focus on helping her find a women's shelter or other emergency housing in the community.
- Advise a woman who fears for her safety that she should call 911 at any time (provided she is in an area with this service).

Chapter 14: Immediate Concerns After Identification: Follow-up and Referrals

- Be knowledgeable about community agencies and shelters, the services they offer, the languages spoken and the referral process.
- Provide relevant information to the patient about community agencies and shelters.
- If appropriate, make a referral to another professional, and always routinely follow up with the patient about the referral made.
- Whenever possible, meet with the patient in private.
- If abuse is suspected but a language barrier prevents its discussion, consider referring the patient to a physician who speaks her language.
- Keep the information provided by the patient confidential.

Chapter 15: Working Toward a Team Approach to Dealing with Woman Abuse

- Provide expert medical services to abused women.
- Recognize the importance of other health, social and legal services, and know how to access them.
- Through collaboration, work with community service providers to offer optimum care to abused women.

Chapter 16: Managing Woman Abuse When Both Partners Have the Same Physician

General comments

- If a physician does not feel confident in dealing with abuse or the possibility of it, or feels that his or her judgement is affected by a personal bias or by the existence of the dual relationship, an offer of referral is appropriate.
- It is not a conflict of interest to ask a woman about the possibility of abuse or to have an active management plan when abuse is suspected or confirmed and the male partner is also a patient.
- The needs of female and male patients should be addressed independently such that their rights to autonomy, confidentiality, honesty and high-quality care are maintained.
- Reference to the possibility of abuse or confirmation of it based on the assessment of the female should not be noted in the medical chart of the male partner.

- Information gained from the male partner about the abuse should not be recorded in the medical record of the female patient.
- Posters, pamphlets and other information about wife abuse for both male and female audiences should be in the waiting rooms, washrooms and examination rooms.
- When abuse is suspected or confirmed, a woman should be interviewed without the male partner present.
- Physicians need to know and act accordingly if they practise in a jurisdiction where they are required (or permitted) by law or by legislation to report cases in which there is a threat of serious harm.

Confidentiality

- The first action when dealing with abuse is to affirm to the woman that her health and safety are important and that her confidentiality will be protected, unless disclosure is required by law.
- There should be no discussion about the suspected or confirmed abuse with the male partner unless the woman consents to it.
- If there is a discussion with the male partner about the abuse, the information should not be discussed with the woman unless the male consents to it.
- Office staff should not to leave messages about appointment times, tests, or results with partners or on home answering machines. A woman who has not yet confirmed abuse may agree to having physicians or their office staff leave test results, appointment times, etc., on her home answering machine because she does not want to say why she prefers this not be done.

Recognizing and managing abuse

- When abuse is suspected or confirmed (and there is no conflict of interest in cases of dual relationships), it is important to determine the risk to safety since this will guide the discussion about how to proceed.
- It is important when conducting an assessment of the risk to safety that a physician is not influenced by information he or she has about the male partner; it is easier to respond to the magnitude and severity of the injuries when the woman is dealt with independently.
- If a woman agrees to having the physician contact the male partner, it is important that a safety plan be in place as her disclosure of the abuse may put her at risk of retaliation if the male is confronted.
- With the woman's permission, a physician may introduce the topic of abuse with the male partner. A previously scheduled patient visit is the best time to act on this plan. It is unclear whether initiating contact with the male partner is appropriate or not.
- If both partners are patients, offering individual counselling is appropriate provided that the physician is trained to deal with violence. Offering a referral is also appropriate.
- It is generally inadvisable to attempt joint or marital counselling and this should be attempted only if the violence has ended. Physicians must have a high level of expertise and confidence that they can conduct such counselling without escalating the violence, and they must have training specific to dealing with violent relationships.
- The possibility of joint or marital counselling should be raised with the woman first without the male partner knowing it is a possibility. Some abused women are so controlled by their abusive partners that they may consent because of pressure from or fear of the partner.

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